

Emotional and Behavioral Problems and Severe Academic Delays among Sheltered Homeless Children in Los Angeles County

ABSTRACT

Objectives. Few studies have estimated the extent of specific emotional, behavioral, and academic problems among sheltered homeless children. The objectives of this study were to describe such problems, identify those children with the problems, and evaluate the relationship between child problems and use of physical and mental health services.

Methods. From February through May 1991, 169 school-age children and their parents living in 18 emergency homeless family shelters in Los Angeles County were interviewed. To evaluate the answers, interviewers used standardized measures of depression, behavioral problems, receptive vocabulary, and reading.

Results. The vast majority (78%) of homeless children suffered from either depression, a behavioral problem, or severe academic delay. Among children having a problem, only one third of the parents were aware of any problem, and few of those children (15%) had ever received mental health care or special education.

Conclusions. Almost all school-age sheltered homeless children in Los Angeles County have symptoms of depression, a behavioral problem, or academic delay severe enough to merit a clinical evaluation, yet few receive specific care. Programs targeted at sheltered homeless school-age children are needed to close this gap. (*Am J Public Health*. 1994;84:260-264)

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Introduction

Families with children are the fastest growing homeless population, making up possibly as much as 40% of the homeless.^{1,2} Almost a quarter of the homeless are children and at least 3% are unaccompanied youth.² On any given night, it is estimated that 68 000 to 100 000 children have no home and that an additional 186 000 are doubled up in overcrowded conditions.³ In Los Angeles County alone, the number of homeless children is conservatively estimated to be between 32 000 and 36 000 over a 1-year period.⁴

Living in extreme poverty, homeless children experience substandard living conditions, abrupt residential transitions, and discontinuity in school.⁵⁻⁷ They are also often raised by a single parent with limited education and inadequate economic and social supports,⁸⁻¹⁰ which exacerbates the stress within the family. Earlier studies found that approximately one half of sheltered homeless children in Boston suffer from at least one developmental delay or require psychiatric evaluation for depression or anxiety,¹¹ and that a majority of children living in Philadelphia's public homeless shelters and New York City's hotels have extremely poor receptive vocabulary and visual motor skills.^{9,12,13} Furthermore, many homeless children suffer from untreated acute and chronic physical illnesses^{12,14-17} and are without a regular health care practitioner.^{14,16,18}

Our study focuses on emotional disorders and severe academic delays among school-age sheltered homeless children living in one of the country's largest metropolitan counties. We targeted school-age sheltered homeless children so we could investigate those children who are most accessible to services through

schools and social services while still living with their family, and we included Mexican and Central American families, a population rarely described in the homeless literature. Our objectives were to (1) describe emotional, behavioral, and academic problems among sheltered homeless children; (2) identify characteristics of homeless children with such problems; and (3) relate the use of health services and specific mental health interventions to child need.

Methods

All 22 emergency homeless family shelters that were in operation during the late winter of 1991 were identified from four Los Angeles County homeless service databases. The shelters were placed in random order and surveyed twice between February and May 1991. All families who had stayed at the shelter at least one night and had at least one child between the ages of 6 and 12 years were asked to participate. The parent who knew the child best was interviewed. If there were more than two eligible children in a family, two were randomly selected. One child with severe mental retardation

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was excluded. Interviews were conducted in Spanish or English, depending on parent and child preference; the survey instruments were translated and back-translated into Spanish. Academic skills were tested in both languages if the child was bilingual, and the best score was taken.

Measures

Sociodemographic characteristics of the parent and child were obtained from the parent. Child ethnicity was categorized as African American, Latino, non-Hispanic White, or Other. This last category included the few children identified by the parent as being biracial, Asian American, or American Indian.

Homeless history questions were adapted from the RAND Course of Homelessness Study (M. A. Burnam and P. Koegel, personal communication, March 12, 1992). Also obtained were the age the child first became homeless, the amount of time the child spent homeless in the past 12 months, the number of different places in which the child lived in the past 12 months, and the number of different times in this past year the child returned to homelessness after having a home or staying with family or friends for at least 30 continuous days. "Homeless" was defined as having no regular place to live, such as a house, an apartment, a room, or the home of a family member or friend, but instead having to stay in a shelter, an abandoned building, an all-night theater, a car, outdoors, or other such places not meant to be a permanent living space.

Both parental awareness of an emotional or learning problem and child use of health services were assessed using questions from the National Health Interview Survey, 1988 Child Health Supplement.¹⁹ If a parent reported that the child had ever had a delay in growth or development, a learning disability, or an emotional or behavioral problem lasting 3 months or more, the parent was identified as being aware of a problem. When a problem was reported, the parent was asked whether the child had received counseling or treatment during his or her lifetime, attended special classes or a special school, or received special help at school in the past 12 months. Whether or not the child had a problem, the parent reported if the child had received routine or sickness or injury care in the past 6 months from any clinic, health center, hospital, or doctor's office.

Depression was evaluated using the Children's Depression Inventory,²⁰ a 27-item child self-report measure of symp-

toms over the past 2 weeks. Examples of symptoms are low self-esteem, poor concentration, insomnia, and a desire to commit suicide. A score above 9 is indicative of the need for psychiatric evaluation.²⁰ Behavioral problems were assessed using the Child Behavior Checklist.²¹ This 118-item scale relies on parental report of child behavior over the past 6 months and is norm-referenced for large populations within and outside the United States. A *T* score equal to or above 60 on the total behavior scale corresponds to the 82nd percentile, the borderline clinical range warranting further evaluation. Given the residential instability and lack of structured social groups available to many homeless children, the social competence scale of the Child Behavior Checklist was not performed.

Receptive vocabulary was measured with the Peabody Picture Vocabulary Test.²² The child was asked to point to one of four pictures that describes the spoken word best. The total score was normed for age. Three reading skills—letter-word identification, word attack, and passage comprehension—were assessed using the reading subtest of the Woodcock-Johnson Language Proficiency Battery.²³ Total reading score was normed for age and grade. Scores at or below the 10th percentile for age were considered indicative of severe delay in receptive vocabulary and reading skills. Below the 10th percentile, a child would be receiving a letter grade of F and functioning at least one grade below grade level. Both instruments had standardized Spanish versions with norms for Spanish-speaking populations.

Data Analysis

Bivariate analysis of discrete variables was performed using a chi-square test of proportions, and analysis of continuous variables was performed using analysis of variance. Linear and logistic regression analyses were used to examine whether the child's homeless history variables and demographic factors (child's age, sex, and ethnicity; parent's age, sex, marital status, education, and income) were uniquely associated with each child mental health problem, and to determine whether specific child mental health problems were uniquely associated with service use, controlling for other factors. The regression models were used to generate predicted levels of need or service use for groups of interest, such as ethnic groups, controlling for all other demographic variables. The reference population for the analysis was all 6- to 12-year-old homeless

children residing in the shelters during the study period. The data were weighted by the number of eligible children per family. The significance statistics and standard errors were adjusted for the correlations in responses for children from the same family by using the intraclass correlation model.^{24,25}

Results

Eighteen of the 22 (82%) of the eligible shelters agreed to participate, representing all seven geographic regions of Los Angeles County. A shelter was eligible if it allowed homeless families to stay at least one night and was an emergency shelter with a length of stay of less than 60 days. Emergency homeless family shelters ranged from missions to publicly funded facilities. Interviews were completed on 118 of 121 (98%) eligible families and on 169 (100%) eligible children.

The majority (93%) of the homeless parents living with children were women from predominantly minority backgrounds. Their mean age was 34 years; one third (34%) were married; and their average education was 11 years. The majority of families (61%) were living in extreme poverty with an annual income of less than \$10 000. The average number of children per family was 3.6, with a range of 1 to 10.

One half of the children were female, and most were from minority backgrounds (Table 1). Approximately 44% of the children were African American, 35% were Latino, 14% were White, and 7% were classified as Other. Fifty-five percent of children were between the ages of 6 and 9 years, and 45% were between the ages of 10 and 12 years (mean age = 9.2 years, SD = 2.0).

The average age the child first became homeless was 7.6 years, with no significant differences between ethnic groups. More than a quarter (26%) of the children had first become homeless more than a year ago, and more than half (52%) had been homeless for more than 2 months over the past year. Almost one half (46%) had lived in more than two places over the past 12 months, and 6% had entered back into homelessness more than twice in the past year after having had a home or stayed with family or friends for at least 30 consecutive days. Compared with children from other ethnic groups, Latino children were more likely to have been homeless for more than 2 months over the past year ($P = .001$), and non-Hispanic White families were more likely

TABLE 1—Child Characteristics and Problems (%), by Ethnicity

	African American (n = 74)	Latino (n = 59)	Non-Hispanic White (n = 23)	Other (n = 12)	Total (n = 169)
Female	54	54	30	42	50
Age group					
6–9 y	51	54	60	69	55
10–12 y	49	46	40	31	45
Homelessness					
First homeless >1 year ago	28	28	32	0	26
Homeless >2 months in past year	41	71**	48	35	52
>Two residences in past year	44	39	79**	38	46
>Two returns to homelessness in past year	7	7	4	0	6
School					
Enrolled now	90	91	76	86	88
Missed >3 weeks over past 3 months	9	17	32	21	16
Problem					
Depression	34	35	48	45	37
Behavioral problem	29	28	24	28	28
Vocabulary delay	63*	42	24	21	47
Reading delay	50**	30	40	14	39

* $P \leq .05$; ** $P < .01$.

TABLE 2—Child Problems (in Percentage of Children Who Received Care), by Mental Health Interventions and General Health Care

	For Mental Health		For General Health in Past 6 Months	
	Counseling/ Treatment over Lifetime	Special Classes in Past 12 Mos	Routine Care	Sickness/ Injury Care
Depression				
Present (n = 64)	23	19	72	62*
Absent (n = 105)	13	5	62	35
Behavioral problem				
Present (n = 49)	30*	17	71	54
Absent (n = 120)	11	7	64	41
Receptive vocabulary delay				
Present (n = 76)	16	14	69	43
Absent (n = 92)	17	6	62	46
Reading delay				
Present (n = 64)	19	19*	69	57*
Absent (n = 105)	15	4	64	37

* $P \leq .01$

to have lived in more than two residences over the past year ($P = .004$). Homeless history did not vary significantly by child's age or sex.

Most children (88%) were registered in school. However, 16% had missed more than 3 weeks of school over the past 3 months.

Thirty-seven percent of the children exceeded the cutoff point for depression requiring a psychiatric evaluation, and 28% scored in the borderline clinical range

for a serious behavioral problem. The correlation between these scores was weak (Spearman $r = .27$). Parent and child demographics did not vary significantly between children with and without emotional and behavioral problems. Based on multiple logistic regression analyses, neither parent and child demographics nor the amount of time homeless nor the number of residences over the past 12 months predicted child depression or behavioral problems.

Forty-seven percent of homeless children scored at or below the 10th percentile in receptive vocabulary, and 39% had a severe delay in reading. That is, when asked to identify which picture corresponded to the spoken word, almost half the homeless children functioned at or below the lowest 10th percentile for children of the same age in the general population, and almost 40% demonstrated reading skills at or below the lowest decile, equivalent to an F letter grade. African-American children had significantly greater delays in receptive vocabulary ($P = .028$) and reading ($P = .001$) than homeless children from other ethnic groups, and this difference remained in the logistic regression analysis that controlled for homeless history, parental history of mental illness, and substance abuse. There were no other significant differences in parent or child demographics.

Among children requiring a psychiatric evaluation for depression, only a minority (23%) had ever received counseling or treatment in their lifetime, and even fewer (19%) had been in special education classes or received special help in school during the past 12 months (Table 2). Moreover, only 30% of those children with a behavioral problem had ever received any counseling or treatment, and even fewer (17%) had been in special education or received additional help in school in the past 12 months. Children with a behavioral problem, however, were more likely to have received counseling or treatment than those without a problem ($P = .001$). There was no significant difference in child age, sex, or ethnicity among those children receiving or not receiving any of these interventions. Only three children identified by a parent as having a problem had ever received medication for an emotional or behavioral problem, a developmental delay, or a learning disability in the past 12 months.

Likewise, only 14% of children scoring at or below the 10th percentile for age in receptive vocabulary had been in special classes or had received additional help in class during the past 12 months. Among children with a severe reading delay, only 19% had received any special education in the past year. Children with a severe reading delay, however, were more likely to receive special education than other children ($P = .001$).

Almost two-thirds (65%) of homeless children had visited a clinic, health center, hospital, or doctor's office for routine health care over the past 6 months, and fewer than half (46%) had received care

for sickness or injury within the same period. Children suffering from depressive symptoms or a severe reading delay were more likely than those without such problems to have visited a health care practitioner over the past 6 months ($P < .001$, $P = .01$).

Among the 78% of children with at least one emotional or academic problem, parents were aware of a problem for only one third of them. Moreover, of those children identified by a parent as having a problem, only one half had received any type of mental health or academic intervention.

Discussion

Most sheltered homeless children in Los Angeles County require clinical evaluation for serious emotional and behavioral problems and severe academic delays. The high prevalence of problems is alarming but not surprising, given that many homeless children not only possess multiple traditional risk factors for mental disorders, such as poverty, stress, and single-parent families,²⁶⁻³³ but also experience stressors perhaps unique to being homeless, such as frequent moves and discontinuity in school at a relatively young age.

The sheltered homeless children studied here were almost 20 times more likely to have depressive symptoms than prepubescent children in the general population.³⁴ Clinical assessment of symptomatic homeless children is needed to determine whether their depressive symptoms correspond to a major mental disorder or are a response to the stress of being homeless, a transient phenomenon, or an artifact of the screening instrument. In an extensive literature review, we found few clues on the validity of the depression measure in low-income minority children.

Similarly, sheltered homeless children in our study were 1.5 times more likely to have symptoms of a behavioral disorder than those children in the measure's large normative general population. As noted elsewhere, race and socioeconomic status have little effect on scale scores of the Child Behavior Checklist,²¹ so our finding is unlikely to be an artifact of the screening instrument.

Homeless children were also approximately four times more likely to score at or below the 10th percentile in receptive vocabulary and reading than children of similar age in the general population. That is, a substantial number of homeless children, although attending school, did not

possess average grade-level reading and receptive vocabulary skills to allow them to learn competitively alongside their housed counterparts. Greater academic delays found among African-American homeless children could reflect a cultural bias in the testing instruments³⁵; however, even when tested and scored in their preferred language, a high percentage of Latino children, as well as of non-Hispanic Whites, had serious academic delays. Both academic measures had large normative samples for English- and Spanish-speaking children.^{22,23}

Yet despite this high need, we found that few homeless children receive treatment. Moreover, a target population of those children most likely to require services could not be identified; demographic characteristics and homeless history parameters did not predict child emotional disorders or academic delays, probably because of the high prevalence of problems and important predictor variables such as poverty status. Thus, service provision and not health screening appears to be the priority for school-age sheltered homeless children. Our study findings offer some insights into how such provision may be made.

Residential instability, a paucity of community mental health clinics, erratic school attendance, and the lack of parental awareness of a child's problem may make it particularly difficult for homeless children to receive services. Hence, mental health and academic interventions for homeless children should be adapted to accommodate the crisis nature of sheltered homeless families and include parental education and mechanisms for continued care once the family obtains stable housing. Furthermore, both the relatively high level of contact with a health care practitioner for routine general health care and the greater likelihood that depressed children receive care for sickness suggest that the general medical sector could be a potentially important point of contact for serving homeless children.

This study has two main limitations. One is the absence of a comparison group of low-income, housed, and predominantly minority children. However, a suitable control group, one that would have a similar distribution of risk and protective factors except for being homeless, could not be identified because of the unique and varying combinations of social and economic disadvantages among homeless families. The other limitation—the exclusion of nonsheltered homeless children—may have resulted in the prevalence of

child problems being underestimated since the number of homeless families unable to obtain emergency shelter is estimated to be greater than the number of sheltered homeless families.³ Furthermore, the study's cross-sectional design and age restriction prohibit conclusions about risk factors for behavioral problems and developmental delays among the larger homeless child population under 6 years of age.³⁶

Despite these limitations, the prevalence of serious emotional problems and severe academic delays reported here suggests that programs for homeless children are needed, regardless of the level of need in any comparison group. The strength of our findings is supported by comparable results from earlier studies based in other major cities^{9,11,12} and by a high participation rate from a diversity of emergency homeless shelters in a heavily populated metropolitan county. Mental health and educational services for homeless children should be a component of a comprehensive package of services that assist families in obtaining permanent housing. These programs could require participation of the schools, shelters, and routine health care practitioners, as well as inclusion of parental education. Without such timely intervention, however, the emotional and behavioral problems and severe academic delays of homeless children will go untreated, threatening the development of these children at a critical period in their lives and robbing them of the fundamental opportunity to gain the emotional tools and academic skills necessary for fully productive and independent lives. □

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